

EXHIBIT 5

Phelps Memorial Hospital Center
701 North Broadway
Sleepy Hollow, New York 10591-1096

1 10/18/06 10/18/06 10/18/06 10/18/06 10/18/06

DT90004

P H E L P S

P EMERGENCY ROOM REGISTRATION

FINANCIAL #	MEDICAL RECORD #	PT TYPE	SVC	CLINIC1	CLINIC2	CLINIC3	CLINIC4	CLINIC5	ADMIT/REG.DATE/TIME
PA0006220723	MR00346473	REG ER		PER					10/18/06 0008
PATIENT NAME/ADDRESS GOMEZ,AWILDA 1 RIVER PLAZA APT4E TARRYTOWN,NY 10591 PHONE: (914)366-8246 SOC.SEC.NO. 073-70-2735 EMPLOYER/ADDRESS/PHONE PRIMARY LANGUAGE SPANISH				FC	ACS	NS	ROOM/BED	REGISTRAR	DISCHARGE DATE/TIME
				AETHA	ER	PER		RECCLAIN	
				PRIMARY CARE PHYSICIAN Carniciu,Stere MD					
				ADMITTING PHYSICIAN					
				ER PHYSICIAN Sapoznikow,Isaac MD					
				PRIOR STAY Phelps Memorial Hospital 08/15/89-08/18/89					
BIRTHDATE	AGE	SEX	M/S	RACE	RELIGION	NEXT OF KIN/ADDRESS			
02/20/1964	42	F	M	HI	CA	GOMEZ,MARIO 1 RIVER PLAZA APT4E TARRYTOWN NY 10591			
HOW ARRIVED: WI				INSTITUTION:		RELATIONSHIP: SP			
ACCIDENT DATE/TIME						HOME PHONE: (914)366-8246			
10/18/06 0008						ALLERGIES:			
REASON FOR VISIT									
PAIN BOTH SIDES OF HER ABD									
COMMENTS									
GUARANTOR/ADDRESS				RELATIONSHIP PT			SOC.SEC.NO.		
GOMEZ,AWILDA				PHONE (914)366-8246			073-70-2735		
1 RIVER PLAZA APT4E				EMPLOYER/ADDRESS/PHONE					
TARRYTOWN,NY 10591									
INSURANCE #/NAME				PLAN#/NAME		ID#/CERT/SSN/HIC		GROUP #	
AETNA.HMO AETNA HMO				01		BBDQRJMB		008040	
PO BOX 981109				PHONE NO. (800)624-0756					
EL PASO TX 79998-1109				AUTH#/BY					
				SUBSCRIBER/INSURED NAME:					
INSURANCE #/NAME				PLAN#/NAME		ID#/CERT/SSN/HIC		GROUP #	
				02					
				PHONE NO.					
				AUTH#/BY					
				SUBSCRIBER/INSURED NAME:					
INSURANCE #/NAME				PLAN#/NAME		ID#/CERT/SSN/HIC		GROUP #	
				03					
				PHONE NO.					
				AUTH#/BY					
				SUBSCRIBER/INSURED NAME:					

FORM 1174 10/2004

Phelps Memorial Hospital Center
701 North Broadway
Sleepy Hollow, NY 10591



351095

CHIEF

Patient Name GOMEZ, AWILDA		Date and Time 10/18/06 0008	Medical Record MR00346473	Account Number PA0006220723
Triage/Nursing Note Reviewed: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		EMS Medical Control: <input type="checkbox"/> Yes <input type="checkbox"/> No	Source of History: <input checked="" type="checkbox"/> Patient <input type="checkbox"/> Interpreter	
		Pre-hospital care reviewed: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Other <input type="checkbox"/> History Unobtainable	
Time of physician evaluation: 12:10		Family/Referring Physician	Chart Copy To	Previous medical record reviewed: <input type="checkbox"/> Yes <input type="checkbox"/> Not available
CC AND HPI 42 y/o H/O ovarian Ca, S/P Hysterectomy Sept 06 while on at on alteration in police, the pt. was pushed to the floor - C/O pain @ ribs and abdomen				
PMH	<input type="checkbox"/> Asthma <input type="checkbox"/> CAD <input type="checkbox"/> CHF <input type="checkbox"/> COPD <input type="checkbox"/> DM <input type="checkbox"/> ESRD <input type="checkbox"/> HTN <input type="checkbox"/> Psych <input type="checkbox"/> Stroke <input checked="" type="checkbox"/> Other: see above			
PSH	<input type="checkbox"/> None <input type="checkbox"/> Yes Specify:		FH	Mother: <input type="checkbox"/> CAD <input type="checkbox"/> DM <input type="checkbox"/> CA <input type="checkbox"/> HTN <input type="checkbox"/> Neg. Other:
			Father:	<input type="checkbox"/> CAD <input type="checkbox"/> DM <input type="checkbox"/> CA <input type="checkbox"/> HTN <input type="checkbox"/> Neg. Other:
MEDICATIONS	<input type="checkbox"/> None <input checked="" type="checkbox"/> Triage/Nursing Notes Reviewed <input type="checkbox"/> See Attached		Siblings:	<input type="checkbox"/> CAD <input type="checkbox"/> DM <input type="checkbox"/> CA <input type="checkbox"/> HTN <input type="checkbox"/> Neg. Other:
Vits, Ca ⁺⁺ , Iron			ALLERGIES	<input checked="" type="checkbox"/> NKA
HABITS	<input type="checkbox"/> Tobacco <input type="checkbox"/> ETOH <input type="checkbox"/> Substance <input type="checkbox"/> Other: <input checked="" type="checkbox"/>		SH	<input type="checkbox"/> Home Alone <input type="checkbox"/> Home Family <input type="checkbox"/> Institution
OCCUPATION			REVIEW OF SYSTEMS	<input type="checkbox"/> ROS Otherwise Unremarkable
PHYSICAL EXAMINATION			General: <input checked="" type="checkbox"/> Negative <input type="checkbox"/> Chills <input type="checkbox"/> Fever <input type="checkbox"/> Malaise <input type="checkbox"/> Weight Loss	
A&P x3, coherent, upset			Eyes: <input checked="" type="checkbox"/> Negative <input type="checkbox"/> Blurred <input type="checkbox"/> Diplopia <input type="checkbox"/> Pain <input type="checkbox"/> Redness <input type="checkbox"/> Photophobia <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataracts	
Head NC/AT			ENT: <input checked="" type="checkbox"/> Negative <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Sore throat <input type="checkbox"/> Tinnitus <input type="checkbox"/> Vertigo <input type="checkbox"/> Sinusitis	
Eyes pink			Cardiac: <input checked="" type="checkbox"/> Negative <input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Dyspnea <input type="checkbox"/> Orthopnea <input type="checkbox"/> PND <input type="checkbox"/> Edema <input type="checkbox"/> RHF <input type="checkbox"/> Murmurs	
ENT moist mucosae			GI: <input checked="" type="checkbox"/> Negative <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Melena	
Neck supple, no tenderness			<input type="checkbox"/> Hematemesis <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Jaundice	
Back no tenderness			GU: <input checked="" type="checkbox"/> Negative <input type="checkbox"/> Dysuria <input type="checkbox"/> Frequency <input type="checkbox"/> Urgency <input type="checkbox"/> Nocturia <input type="checkbox"/> Pyuria <input type="checkbox"/> Retention <input type="checkbox"/> Discharge	
Lungs clear			GYN: <input checked="" type="checkbox"/> Negative <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Vaginal Bleeding S/P hysterectomy	
Heart RRR S2, N2 @			SKIN: <input checked="" type="checkbox"/> Negative <input type="checkbox"/> Rash <input type="checkbox"/> Sweaty <input type="checkbox"/> Pruritus	
Abdom tender @ ribs			Resp: <input checked="" type="checkbox"/> Negative <input type="checkbox"/> Cough <input type="checkbox"/> SOB <input type="checkbox"/> Hemoptysis	
Abd +BS, soft, voluntary guarding			NEURO: <input checked="" type="checkbox"/> Negative <input type="checkbox"/> Seizure <input type="checkbox"/> Dizziness <input type="checkbox"/> Syncope <input type="checkbox"/> Weakness/Numbness <input type="checkbox"/> Paresthesia <input type="checkbox"/> Migraines	
? Diffusely tender			Psych: <input checked="" type="checkbox"/> Negative <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Suicide	
			Endocrine: <input checked="" type="checkbox"/> Negative <input type="checkbox"/> Heat Intolerance <input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Thirsty <input type="checkbox"/> Polyuria	
			Heme: <input checked="" type="checkbox"/> Negative <input type="checkbox"/> Bleeding <input type="checkbox"/> Bruising	
			MS: <input type="checkbox"/> Negative <input type="checkbox"/> Back Pain <input type="checkbox"/> Joint Pain <input checked="" type="checkbox"/> Myalgia PM Rb cage	
			Immune: <input checked="" type="checkbox"/> Negative <input type="checkbox"/> Immunization reviewed <input type="checkbox"/> Allergies	
			Other	
			Consult # 1	Consult # 2
			Name:	Name:
			Time Called:	Time Called:
			Phone Response:	Phone Response:
			Arrival:	Arrival:
ED Attending Physician Signature		Private Attending Signature		Health Care Provider Signature

2. Sapoznikow, MD

MEDICAL RECORDS

346473, 6220723, GOMEZ, AWILDA Printed by: Veronica Merello

Phelps Memorial Hospital Center
701 North Broadway
Sleepy Hollow, NY 10591

Department of Emergency Medicine
Medical Record

Patient Name GOMEZ, AWILDA		Date and Time 10/18/06 0008	Medical Record MR00346473	Account Number PA0006220723
Time	DIAGNOSTIC ORDERS	Order Entry By	Time	MEDICATION ORDERS
	<input type="checkbox"/> ECG <input type="checkbox"/> ABG <input type="checkbox"/> Lab Tests Reviewed			<input type="checkbox"/> Td 0.5 cc IM
	UP			Lot #:
				Exp: Site:
				<input type="checkbox"/> Hypertet 250 units IM
				Lot #:
				Exp: Site:
				0055 Dilaudid 1mg IM - (C) RF
				vicodin 5/500 tabs #2
				to take at home tonight prn
				125 levaguin 250mg po
				140 Toradol 60mg (C) RF
ED PHYSICIAN/PRACTITIONER INTERPRETATION - EKG				
RADIOLOGY ORDERS		SIGNS/SYMPTOMS	RADIOLOGY INTERPRETATION	
CXR (C) R/L		R/O	No rib fr. No PTX	
RUA		fall	Nonspecific	
		Pain		
IMPRESSION: Contusion (C) Rib cage			DX Code	CRITICAL CARE TIME: _____ due to: _____
UTI			<input type="checkbox"/> Continuation Sheet Attached	
TREATMENT: Rest as needed				
levaguin 250mg po QID x 5d				
Adolc PRN for pain				
RESTRICTIONS <input type="checkbox"/> No Work <input type="checkbox"/> No School <input type="checkbox"/> No Gyn <input type="checkbox"/> Limited activity <input type="checkbox"/> 1 Day <input type="checkbox"/> 2 Days <input type="checkbox"/> 3 Days				
<input type="checkbox"/> Use Prescribed medications as directed on the bottle <input type="checkbox"/> Use acetaminophen, aspirin, or ibuprofen as follows: _____ every _____ hours, for _____ days				
ADDITIONAL INSTRUCTIONS/PRESCRIPTIONS				
<input type="checkbox"/> Follow up with your doctor or Dr. _____ in _____ days/hours, for _____ Telephone: _____				
<input type="checkbox"/> DOA		<input type="checkbox"/> Expired		Condition:
ME Notified: <input type="checkbox"/> Yes <input type="checkbox"/> No		ME Accepted: <input type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" type="checkbox"/> Satisfactory
ME Name: _____		Case Number: _____		<input type="checkbox"/> Improved
				<input type="checkbox"/> Unchanged
				<input checked="" type="checkbox"/> Stable
ED Attending Physician Signature: _____		Private Attending Signature: _____		Health Care Provider Signature: _____

DATE: 09/25/07 @ 1114
USER: JDABBS

Phelps Memorial Hospital EDM *LIVE*
EMERGENCY ROOM MEDICAL RECORD

PAGE 1

Patient: GOMEZ, AWILDA
ED Provider: Sapoznikow, Isaac MD

Age/Sex: 42/F

Acct No: PA0006220723
Unit No: MR00346473

Demographic

1 RIVER PLAZA APT4E
TARRYTOWN, NY 10591
(914)366-8246

Insurance: AETNA HMO
Next of Kin: GOMEZ, MARIO
Relation: 02 SPOUSE
Phone: (914)366-8246

PCP: Carniciu, Stere MD
Family Doctor:

Triage

10/18/06 0002 ED Triage

Kyle Irish

Stated C/O PAIN BOTH SIDES OF HER ABD. S/P ASSAULT FROM PD BREAKING UP A DOMESTIC
Cause Altercation

General Appearance Mild Distress, Anxious

GCS 15

Patient Orientation A&O X3

Pupil Bilateral

Pupil Reaction PEARLA

Lung Sounds Clear

Respirations Normal

Appearance / Behavior Anxious, Agitated

BP Systolic 134

BP Diastolic 100

Pulse 160

Temp 98.2

Temp. Source Tympanic

Resp 24

SAO2 100

Pain Intensity 5

Pain Scale Used Adult

Comfort Goal 0

Priority

3

Vital Signs

Time	BP Systolic	BP Diastolic	Temp	Pulse	Resp	SAO2	Pain Intensity	Comfort Goal	User
0155	116	58		68	16		1	0	KIRISH
0347	124	63		68	16		1	0	KIRISH

Vitals Detail

10/18/06 0155 ED Vital Signs

Kyle Irish

BP Systolic 116; BP Diastolic 58; Blood Pressure Position Supine; Pulse 68; Resp 16;
Pain Intensity 1; Pain Scale Used Adult; Comfort Goal 0

10/18/06 0347 ED Vital Signs

Kyle Irish

BP Systolic 124; BP Diastolic 63; Blood Pressure Position Supine; Pulse 68; Resp 16;
Pain Intensity 1; Pain Scale Used Adult; Comfort Goal 0

CMAXX:MR00346473~PA0006220723~MTEDREC-10/18/06 Patient:GOMEZ, AWILDA

DATE: 09/25/07 @ 1114	Phelps Memorial Hospital EDM *LIVE*	PAGE 2
USER: JDABBS	EMERGENCY ROOM MEDICAL RECORD	
Patient: GOMEZ, AWILDA	Age/Sex: 42/F	Acct No: PA0006220723
ED Provider: Sapoznikow, Isaac MD		Unit No: MR00346473
Medical/Surgical History		
10/18/06 0115 ED Medical/Surgical History		Kyle Irish
Allergies		
No Known Allergies		
DNR / Advance Directives		
10/18/06 0115 Kyle Irish		
DNR N		
Copy on Chart? N		
Assessments		
10/18/06 0350 ED Abdominal Pain		Kyle Irish
Assessment Reassessment		
Date 10/18/06		
Cause Of Complaint Altercation		
Location Of Pain Abdomen		
Type Of Pain Cramping		
Abdominal Pain Location LLQ, RLQ		
Pain Intensity 3		
General Appearance Mild Distress, Anxious		
Bowel sounds Present		
Palpation Soft		
ABD Pain Location LLQ, RLQ		
Inspection Flat		
Location Throughout		
Lung Sounds Clear		
Notes		
Entered by Kyle Irish on 10/18/06 at 0226		
PT MUCH MORE RELAXED WITH HER DAUGHTERS IN-TOW, NO MORE HYPERVENTILATION. PT GIVEN DILAUDID AND TORADOL FOR PAIN, LEVAQUIN FOR UTI. PT WILL HAVE TO INCREASE FLUIDS AND REST. FOLLOW UP WITH PMD		
Entered by Kyle Irish on 10/18/06 at 0351		
PT SENT HOME TO REST WITH DAUGHTER, RX AND MEDS GIVEN		
Orders		
Ordered	Procedure Name	Ordering Provider
10/18/06 0023	URINALYSIS	Sapoznikow, Isaac MD
10/18/06 0023	XR RIBS LEFT W/PA CHEST	Sapoznikow, Isaac MD
10/18/06 0023	XR ABD FLAT AND ERECT OR DECUB	Sapoznikow, Isaac MD
		E-Signed
		No
		No
		No
Discharge & Procedure		
10/18/06 0335 Kyle Irish		
Departure D/C Home		
Mode Of Discharge Family		
Notify F/U MD Form		
CMAXX:MR00346473~PA0006220723~MTEDREC~10/18/06 Patient:GOMEZ,AWILDA		

DATE: 09/25/07 @ 1114
USER: JDABBS

Phelps Memorial Hospital EDM *LIVE*
EMERGENCY ROOM MEDICAL RECORD

PAGE 3

Patient: GOMEZ, AWILDA
ED Provider: Sapoznikow, Isaac MD

Age/Sex: 42/F

Acct No: PA0006220723
Unit No: MR00346473

Departure/Disposition

Disposition: 01 HOME, SELF-CARE
Diagnosis:
Comment:
Condition:

Departure Date/Time: 10/18/06 - 0336

Pt Instructions: URINARY TRACT INFECTION-PHELPS

Departure Forms: DISCHARGE INSTRUCTIONS - ENG

CMAXX:MR00346473-PA0006220723-MTEDREC-10/18/06 Patient:GOMEZ, AWILDA

Patient Name: GOMEZ, AWILDA
 Date: 10/18/06 Time: 0336

Account Number: PA0006220723

PHELPS MEMORIAL HOSPITAL CENTER
 701 NORTH BROADWAY
 SLEEPY HOLLOW, NY 10591

Emergency Department Discharge Instruction:

The examination and treatment you have received within the Department of Emergency Medicine was an emergency treatment only. It was directed primarily to the emergent problem.

Emergency treatment is not intended to be a substitute for the complete and comprehensive medical care rendered by your personal care provider. It is difficult to recognize and treat all elements of injury or illness in a single visit. It is difficult to treat non-emergent or chronic conditions on an emergent basis within a Department of Emergency Medicine.

If new symptoms should develop or if your condition becomes worse and you cannot reach your medical provider, return to the Department of Emergency Medicine

Conditions may change in the course of hours and new unforeseeable complications may ensue. It is, therefore, essential that you secure a follow-up examination and treatment by arranging an appointment with your own physician indicated below. Meanwhile follow instructions below. Notify your family doctor or the doctor we referred you to that you were treated in this emergency department. Further follow up care will be carried out by him/her as necessary.

XRAYS: The interpretation of your x-ray(s) was given to you by the emergency physician is only a preliminary report. The x-ray specialist reviews these films. If there is a change in the diagnosis, you or your doctor will be notified. Sometimes fractures or abnormalities may not show up on the xray(s) for several days. If symptoms persist or get worse, additional xrays may have to be taken.

LABS: If laboratory results were not received while you were in the Emergency Department (such as cultures etc) you will be contacted if additional treatment is required.

RESTRICTIONS: ☐ No Work ☐ No School ☐ No Gym ☐ Limited Activity
 ☐ 1 Days ☐ 2 Days ☐ 3 Days

Use prescribed medication as directed on the bottle:

Medication Instructions Sheets given? YES ☒ NO ☐

Use Acetaminophen, Aspirin or Ibuprofen for _____ as follows:

_____ every _____ hours for _____ days

Additional Instructions/Prescriptions:

*Rest, fluids, Leg with 25mg Po Once a Day,
 Motrin q 4hr with food for pain*

Patient Name: GOMEZ, AWILDA

Account Number: PA0006220723

Discharge Instructions:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Bells Palsy	<input type="checkbox"/> Bursitis	<input type="checkbox"/> Cast Care	<input type="checkbox"/> CHF
<input type="checkbox"/> Inhaler				
<input type="checkbox"/> Peakflow				
<input type="checkbox"/> Conjunctivitis	<input type="checkbox"/> Constipation	<input type="checkbox"/> Costochondritis	<input type="checkbox"/> Croup	
<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Ehrlichiosis	<input type="checkbox"/> Eye Care		
<input type="checkbox"/> Fussy Baby	<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Hemorrhoids	
<input type="checkbox"/> Colic				
<input type="checkbox"/> Teething				
<input type="checkbox"/> Diaper Rash				
<input type="checkbox"/> High Bld Pressure	<input type="checkbox"/> High Fever	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Lymes Disease	
<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Neck/Back Injury	<input type="checkbox"/> Nurse Maid Elbow	
<input type="checkbox"/> Otitis Media	<input type="checkbox"/> Rabies	<input type="checkbox"/> Rib Fracture	<input type="checkbox"/> RSV	
<input type="checkbox"/> STD	<input type="checkbox"/> Sprain/Strain Fracture Care	<input type="checkbox"/> Tetanus		
<input type="checkbox"/> UTI	<input type="checkbox"/> Vaginal Bleeding	<input type="checkbox"/> Vomiting and Diarrhea		
<input type="checkbox"/> Wound	(during early pregnancy)			

Follow up with your doctor or Dr. Carnicio, telephone _____
in _____ days / for _____.

The emergency department charges are not an all inclusive fee. It does not include charges for diagnostic procedures, treatments, drugs or supplies, nor does it include charges for the emergency department physician, private or consultanting physicians whose services are necessary for your care. The billing for the radiologist's fee, hospital services and the emergency physician's fee are separate.

Return to the Emergency Department or contact your physician if you are not improving or your condition becomes worse.

I hereby accept, understand and can verbalize these instructions:

Awilda Gomez

Nurse Signature: [Signature]

Date/Time

10/18/06
340

Phelps Memorial Hospital Center
 Department of Pathology and Clinical Laboratories
 Rudolf Ulirsch, M.D., Director
 701 North Broadway
 Sleepy Hollow, NY 10591
 PHONE (914) 366-3910 FAX (914) 366-1525

Name: GOMEZ, AWILDA Age/Sex: 42/F Admit Date: 10/18/06
 Acct#: PA0006220723 DOB: 02/20/1964 Disch Date:
 Med Rec#: MR00346473 Ordering MD: Sapoznikow, Isaac MD
 Location: PER R/B:

*****URINALYSIS*****

URINALYSIS MACROSCOPIC

Day	1			
Date	10/18/06			
Time	0040		Reference	U
SOURCE, UR	RANDOM			
COLOR, UR	YELLOW			
CLARITY, UR	HAZY H		(CLEAR)	
SPECIFIC GRAV, UR	1.025		(1.003-1.035)	
PH, UR	6.5		(5.0-8.0)	
PROTEIN, UR	1+ H		(NEGATIVE)	
GLUCOSE, UR	NEGATIVE		(NEGATIVE)	M
KETONES, UR	TRACE H		(NEGATIVE)	
UROBILINOGEN, UR	0.2		(<=1.0)	E
BILIRUBIN, UR	NEGATIVE		(NEGATIVE)	
BLOOD, UR	NEGATIVE		(NEGATIVE)	
NITRITES, UR	NEGATIVE		(NEGATIVE)	
LEUK ESTERASE, UR	SMALL H		(NEGATIVE)	

URINALYSIS MICROSCOPIC

Day	1			
Date	10/18/06			
Time	0040		Reference	U
RBC, UR	0-2		(0-2)	/
WBC, UR	5-10 H		(0-2)	/
EPITH CELLS, UR	1+ H		(NEGATIVE)	
BACTERIA, UR	OCC		(NEGATIVE)	
MUCUS, UR	1+ H		(NEGATIVE)	

20061018 2202 DISCHARGE SUMMARY REPORT Patient: GOMEZ, AWILDA
 Page: 1 End of Report DO NOT DESTROY PER

Phelps Memorial Hospital
701 North Broadway
Sleep Hollow, New York 10591
Department of Radiology
914-366-3455

Patient Name: GOMEZ, AWILDA Location: PER
Med Rec #: MR00346473
Account #: PA0006220723
Date of Birth: 02/20/1964 Attending:
Age: 42 Sex: F Ordering: Sapoznikow, Isaac MD
PCP: Carniciu, Stere MD

Exam Date 10/18/06
Exam: XR ABD FLAT AND ERECT (COMMON); XR RIBS LEFT W/PA
CHEST
Order#: XR 1018-0010; 1018-0011

HISTORY: abdominal pain, left-sided chest pain

Chest:

Multiple views fail to demonstrate any fracture, pleural fluid, or pneumothorax. The heart is normal in size and the lung fields are otherwise clear, except for minimal bilateral apical pleural thickening. There is no evidence of congestive heart failure or active infiltrate.

Abdomen:

Supine and erect views of the abdomen demonstrate a very large amount of fecal material throughout a normal caliber colon to the level of the rectum. No dilated gas filled loops of small bowel are evident and the stomach is not abnormally dilated. There is no evidence of free air or mass. Multiple left pelvic calcifications most likely represent phleboliths, although the possibility of a distal ureteral calculus cannot be entirely excluded.

***Electronically Signed ***

Steven Kroop MD 10/18/06

Dictated on 10/18/06 0830
Edited by: Phelps Radiologist

Report cc: Sapoznikow, Isaac MD;